Hospital Emergency Incident Command System, An Introduction (August 28, 2003)

CHERYL STARLING: Good morning and afternoon, everyone.
My name is Cheryl Starling and I'm from the State of California and I'm a disaster medical specialist and also the coordinator for California for the Hospital Emergency Incident Command System.
I'll be presenting to you today the Hospital Emergency Incident Command System.
One of the things I want to do right off the bat is thank Rick and Andrea for bringing this to all of you here today.
This is a great opportunity for a lot of people to hear the message and that's what this is all about.
My understanding from this program is that we will not be taking questions during the program.
However, you can ask questions at the end of the program and I'll leave it to the program people to explain how that works at some point.
But I'm going to go ahead and launch because we're a little bit late, launch into the course and hope you've had a chance and opportunity to download the materials.

Welcome, everyone, it's my pleasure to be here today and have the opportunity to present the Hospital Emergency Incident Command System, also known as HEICS to all of you.
One thing I have to start with right away is the difference between hicks and HEICS.
I like to call it HEICS so you'll hear it both ways and equally appropriate, but you'll hear me say no it's HEICS whenever you hear it.
You'll hear me today call it HEICS.
Next slide or the second slide.
One of the things we all know is that emergency response is really not business as usual.
And what we have to do is go from our day-to-day operations into disaster operations.

And it's when to make that convergence, how to make that convergence in your day-to-day operations is really a decision that has to be made at a really administrative level within our system.
One of the things, as I've been presenting HEICS across the country is there is a lot of confusion about ICS and HEICS.
So what I'm going to do in the first part is really talk about the Incident Command System and then lay out for you the similarities and differences in the HEICS system from basic ICS.
If you are real experts on ICS please forgive this redundant section I'm about to go through.
Let's go through it, shall we?
What is the Incident Command System?
The Incident Command System is really a model tool and it really gives you command, control and coordination.
Next slide.

The efforts that happen when an incident occurs, there are multiple agencies that need to converge upon the incident scene or area and they need to have coordination to stabilize the incident, protect life, property and, of course, the environment.
We never can forget our environment.
When is ICS used?
I know I'm preaching to the choir here.

ICS is used any time there is a comprehensive resource management strategy that is needed.
Especially when that management and coordination of an incident requires multi-agency and multi-faceted response.
There is never a better time as when multi-agencies try to come together with very different, unique needs.
Very different and unique issues, and have to go through those together.
Somebody needs to be in command and control of all of that.
I want to spend just a moment on the history of the Incident Command System.
As most of you know, FIRESCOPE, or the firefighting resources of California organized for potential emergencies was the first to develop the ICS.
We must recognize our military partners in that definitely FIRESCOPE was based on a military model.

Customizeed, of course, to the fire situation or the fire discipline.
It's also been used-in-law discipline widely and extensively subsequent to fire and really a great model for community response.
FIRESCOPE again is -- responds to multi-agency issues, especially terminology that needs to be standard so we're all talking the same language.
The ability to expand and contract if there is an incident so if you don't need as many fire trucks on scene, you don't ask for as many fire trucks as you can get.
You ask for what you need.
Any time you have communications that is a huge issue because you have to have standardization so you know how to talk to one another.
There is nothing worse than having a group of people located somewhere and you don't know where they are and you can't communicate with them to get them to the right place.
Action planning as you all know is essential.

Lacking designated facilities for command posts and they're scattered across the area and command isn't collaborated is really a hard issue to solve.
The components of the ICS organization are as you see them on the slide.
Command, planning, operations, logistics and finance/administration.
One of the unique facets of the ICS organization is, like I mentioned before, the ability to expand and contract to meet the needs of the incident.
And we must stress that all incidents, whether large or small, should always have an identified incident commander.
And again, what are the priorities of expanding and contracting?
Life safety, incident stability and property conservation.
Which also includes our environment.
ICS concepts and principles that are imperative to understand are part of an ICS structure are some of the things I've already talked about.
I won't read them down to you.

However, I do want to point out a couple of things in this slide.
The manageable span of control is very important and the other thing that's important on here is a unified command structure.
We're going to be talking about that more in depth.
But if you have a highlighter go ahead and highlight a couple of those things on there that you think are important because all of this really makes its way into the HEICS system to show those similarities.
Again, FIRESCOPE or ICS is a modular organization.
It's really a top down approach.
With functional sections.
So as you see on this slide, you'll see the incident commander, the liaison officer, safety and security, information and then, of course, the important

section chiefs and sections which is logistics, planning, finance and operations.

This is a really important organizational chart for everyone to know about because this is really the nuts and bolts of what HEICS is built from.
As I mentioned to you, we're going to be talking about span of control and in the book the technical book that everybody says the reference or whatever that is, they always talk about optimal span of control.
In references you'll see anything from one to seven as the -- or eight as the optimal span of control.
What we've tried to do in ICS is understand that each person can only have so much input before they go crazy.
So optimal span of control we're trying to reach is one to five with a supervisor only getting input and overseeing five people at a time.
Just makes things a lot easier to control data.
It also fits very well in with that modular concept of the reporting up to the commander.

I want to talk a moment about integrated action plans.
And everybody knows that when you have an incident or anything that occurs and you don't have a common mission and goal, you really don't have a coordinated response.
So whenever you start a response of any kind to a scene or to an incident, it should really be used especially whenever multiple agencies are involved or multiple departments are involved.
I want to underscore both the agency jurisdictions and departments.
If the incident is complex, that means you need more people to manage that incident thereby expanding as needed.
Let's talk about ICS in the hospital setting.
And let's talk about how it merges across into the hospital setting.
We'll go to the next slide.
Oh oh, it's Friday night at 7:00 p.m. So you know what your hospital looks like, right?

Not a lot of supervision, not a lot of extra staff hanging around and you have any or all of these things suddenly occur.
What do you do next?
Well, if you're like any formal disaster recovery plan, help help is usually what we shout first.
That works for about 30 seconds and then somebody needs to get their heads under them and make a plan and have a plan to work off of.
So that's what we're going to be talking about today is how the HEICS system or HEICS plan can help you accomplish that.
These days, hospitals face many types of disasters.
You can see a few of them on the screen.
But the new threats that are now being faced with Hazmat, violence, anything that can happen not only inside the hospital, but external to the hospital, really brings new threats to the hospital environment.
We like to talk about the nature of the problem and I'm going to do this broadly.

But in my way of looking at it, there is really three problem or events that need to be looked at.
One of the multi-casualty incident.
They can be internal but mostly they're external.
They can be localized or widespread but they're really short term crises.

There is a 20-car pileup and the hospital is going to be inundated with victims or there is a train wreck and you know there will be inundation of victims so you ramp up.
However, with an event that does not go on for a terribly long period of time. There are usually a number of casualties that come in, it levels off and the goes down in a fair amount of time.
It has a bell-shaped curve and it has a begin, a peak and an end.
That's usually a multi-casualty incident.
Another type of incident that hospitals must recognize is that there can be internal incidents that occur that can be isolated.
However, those can include fire Hazmat, strikes, it can also include the hospital as a primary or secondary target and so an incident occurs within your facility, an act of terrorism or an act of destruction and you can have an internal event which may have long-term impact on your facility.
For example, if your emergency department was contaminated you would have to do things to make sure that you had a place for your emergency department to have and see patients if they couldn't use the existing facility.
That could be a potentially fair amount of time that would need to be addressed and would need to be an internal incident.

Now, fortunately we haven't had these -- many of these in the next type in the United States.
However, there is that large scale disaster.
It can be natural disaster or manmade.
It can be community wide, statewide or hopefully never nationwide.
It's usually longer in duration and as joint commission likes to say now, it's a longitudinal event.
There might be a peak, but instead of the peak thrusting down and ending it could go on for days, weeks, months.
And so long-term large-scale disasters can really cause a mass influx of victims and, of course, that section of our population called the worry well who really can be sometimes more challenging to deal with than the actual victims of an incident.

So those are the different kinds of problems that can occur.
Bottom line, what kind of problems do each of these levels of problems bring to the hospital facility?
Well, number one, you have a disruption of your day-to-day services and your day-to-day operations.
For example your staff may have to go from eight hour to 12 to 16 hour shifts to cover it.
Staff may not be able to get into the facility to assist with staffing issues or you may have staff whose anxiety level is high that they call in sick and can't get there.
So you definitely have a staff disruption.
You also have that patient care disruption.
For example, if your facility is clamped down to a contamination incident your facility can't get Mrs. Jones who comes in for her Coumadin level and those outpatient lab tests, outpatient radiology and surgery.
All those things that you would have to stop should the incident occur.
That patient care disruption can be huge.
It has absolute financial impact on the hospital.
Dollar bottom line.

And that's why it's a huge problem for hospitals that are usually self--- non-profit and self-paid that those disruptions can cause large bottom dime problems.

Financial impact has to be looked at.
The other thing to look at in patient care disruption is not only what goes on internally but what goes on in the community.
Because when you have a hospital or a clinic or anything that can no longer serve the public or the community in the way they normally do, for example your medical office building might be unaccessible because you're using it as a secondary triage or minor treatment area or whatever you need it for.
The community cannot come in to get their medication refills or get their blood pressures checked or have that patient/doctor visit that they're looking for.
And so literally community care with also be disrupted because those services can't be provided.
Again, financial impact on the hospital can be massive.

I would like to move on to the joint commission and everybody shudders when you hear joint commissions especially if they say they're coming to your facility.
But one of the things joint commission has done in recent years was establish some fairly specific emergency management standards that help bring everyone up to the same level of standard, which is really terrific.
I'm going to report on some of the features of emergency -- environment of care emergency preparedness standard 1.4.
The first thing I would like to mention in EC1.4 is that the Emergency Management Plan, we aren't disaster plans anymore, we're Emergency Management Plans.
It must address the four phases of emergency management.
Those four things must be looked at and addressed in your plan.
EC1.4D also states that you must identified roles and responsibilities of personnel during emergencies who they report to within the command structure and when it gets activated when something happens in the local community.
Those are things we must note when we look at emergency planning.
It also talks about the look of an all hazards approach and that the command structure in the hospital needs to reflect the command structure in the community.
Now, what does that mean?

That means if your local community responders do not use ICS, say they use a different form or a different type or none at all then the hospital really needs to comply and conform to what is used in the command structure within the community.
Most people are now using some form of ICS or unified command and so that links everyone in a much more standard way.
However, it technically does say that you can blink with your command structure within your community.
It doesn't have to be ICS.
EC1.4 also talks about integrating the role in that community response agency.
And if any of you have heard me before, you always know one of my soap box points is that hospitals and community planners must plan together these days and not do it in isolation in order for us to have effective response.
And that also includes co-planning with our local community hospitals, even though they are competitors.
So remember EC1.4 that we need to be community-wide responders and planners.
EC1.4 also talks orientation and education and really they want to see that you've taught people roles and responsibilities during emergencies.
And that specifically is what HEICS can also do for hospitals, provide for -- excuse me everyone.
By providing training materials, etcetera.

Another thing to recognize is that unified command or ICS is recognized by other agencies also.
For example, the 1999 American college of surgeons resources state in chapter 20 that you should determine in advance who is in charge, triage and patient flow, how to handle press, etcetera and that you designate a hospital emergency operations center.
This was a bold statement by the AC, is that really looking at a hospital emergency operations center as an entity, which was very, very good for them to recognize way back in 1999.
Another thing to bring to your attention is the national fire protection agency.
In their section 11-43 they actually state that the disaster planning committee shall model the disaster plan on ICS.
That's out of the NSPA section on hospitals.
Many of you may not have known that they had a section on hospitals but it is is right out of their verbage.
Why do I recite all these laws and regulations to you?

One of the things that the easy to do, it makes it easier, I should say, to do when you want to go to your administration and sell them on why you need to move to an ICS or unified command model, it's often nice to tell them there is regulations out there to help them make that decision.
So that's why I outline a few of the standards and laws that you can utilize to help make people understand why this is important.
Let's go on and talk about some of the shortfalls of past disaster plans.
As you all know, you all look around the room at each other and shake your heads.

You know past disaster plans were those big thick manuals on the shelf that you took down once or twice a year right before your drill, dusted off the top of them, sneezed quite heavily and then opened them to try to find what you needed.
They require a lot of memorization and if you're not the one who knows them and you're not there during the disaster, people were not very easily able to implement the plan because it could be one person's plan, you the disaster planner who locked herself or himself into a room to write it or they're just not user friendly.
The other thing is disaster plans tended not to be in sync with day-to-day management.
People would put on a special hat and lost in that role.
That was definitely a shortfall.
Again like I mentioned when the manageers weren't present the plan usually didn't work because of non-user friendly as well as a complicated plan is very hard to know.

Nowadays staff work in more than one facility and wouldn't it be lovely that in your community you can only -- if someone works at hospital X and they've had the emergency management training that they can go to any hospital in that community as they moonlight and not have to repeat it at every hospital.
That's a goal and a vision I have for the future is that we can standardize training so that hospitals don't have to repeat the annual competency training all over the place.
And like I said before, threats and liabilities are more than ever and we have to be able to match the incident and manage it as much as possible.
So what is the goal?
What is the goal of why we're here today?
It's to help the hospital do two things which I think are absolutely essential when there is an emergency.

Number one is to respond, and respond, everybody knows what that is, to manage the victims, treat, triage and disposition them as fast as possible.
The second thing we need to remember is that the goal is also recovery.
Because we need to get back to operational and financial normal op as soon as possible.
You're all going to say when I ask, when does recovery effort start?
It starts the minute your response begins.
So someone needs to keep their eye on recovery while you're responding, even in the heat of battle.
So those are the two goals for the hospital.
Response and recovery.
Of course, why we're all here today, what is the tool for response and recovery?
Well, I like to think it's the hospital emergency Incident Command System or HEICS.
What is the history of HEICS?

Very quickly, that grants were given to one of our local EMS agencies in 1992.
When they started to look around and say this FIRESCOPE and ICS stuff as merit and we should look at this and see how it could better work in hospitals.
The 1992 plan was written and in 1993 was modeled into many hospitals in California.
In 1996 it was then updated and again in 1998.
As you well know 1998 was a long time ago.
In 1997 before they did the 1998 version, a hospital survey of all those hospitals using HEICS was done.
One of the things they did not want to do was throw the baby out with the bath water and recreate a wheel especially when all of the hospitals were using it.
What they did was they took the information and site visits and interviews and actually streamlined and said what doesn't work for you?
Well, this form doesn't work.
We don't understand this.

So the 1998 version was really the update, not necessarily a rewrite.
And that is something that we're very committed to is not throwing concepts out but updating it to meet current needs.
On this slide you'll also see a website listed.
That is the HEICS website here at the California EMS authority and that page, that link takes you directly to the HEICS page.
I want to say quickly that that link and that HEICS page is going to be revamped and redeveloped to make it more user friendly and also have a more updated information on there.
So soon late September, check that website again and it will look very differently than it does now.
On that website you can download full HEICS manual volume one and volume two.
Please download version three because that's the 1998 version.
That's a reference and a resource for you.
I'll also mention the introductory video mentioned above.
If you want a copy of it you can email me and we'll send you a free copy of the video which is about a 16-minute video that kind of outlines the basic principles of HEICS.

A lot of people use that introductory video in their updates to update the staff on the concept of HEICS.
It's a quick and easy way to do that.
What are the attributes of HEICS?
If you remember back to about 20 minutes ago when we talked about the incident command attributes you'll see a lot of them very much reflected here.

There is a chain in unity of command, flexibility, documentation, adaptability and standardization between facilities like we mentioned before.
And that shared employee.
One of the things we're going to talk about later in this session is the issue of flexibility.
I really want to underscore for you the flexibility of the HEICS plan.
And how you'll see that in action in just a little bit.
Let's talk about what HEICS gives you or what HEICS is.
Really, it's an organizational basis providing guidance, organizational charts, flexible activation and the parallel job functions which I can't say enough about and we'll talk about in just a moment through those standardized job descriptions.

One of the things HEICS provides is a literal standardized job description and check sheet for every position in the organizational chart.
And what a benefit to you to have to just go in and customize for your facility versus starting at the scratch.
I'm going to talk a little more about job action sheets in just a moment.
Again the ICS structure and terminology within the community being standard means that you can understand and talk to your local community responders and they can understand and ask for sections that they're familiar with like the incident command or the planning or the liaison or whatever section they need to talk to.
Also to the next slide, what HEICS is, it is -- it allows training support.
There are lesson plans, exercises.
In addition if you're used to the ones in the manual already you're very welcome to also email me and I'll send you some updated training materials, chemical and some bio stuff if that helps.
What HEICS also is assists in patient tracking and locating.

What an important role in a disaster is to know where Mrs. Jones is and where she resides and where she is now.
If she was dispositioned in a disaster because the family who is pounding on your door trying to find Mrs. Jones are the ones who will give you a lot of trouble.
It also helps track costs and expenses.
That truly is recovery for a hospital.
That has a great deal of value.
What is HEICS -- what HEICS is not.
HEICS is not a turn-key system which means you don't open the HEICS manual and things pop up and you just apply it.
You have to work it.
In addition, you have to apply it.
So it needs practice.
So it's not just a turn it on kind of system.
You have to actively manage and turn it on.

The other thing is one thing, if you take anything away from the presentation today, take this away.
HEICS is not the Emergency Management Plan for the hospital.
HEICS is a tool in the Emergency Management Plan.
It's your command and control and coordination tool.
It is not the Emergency Management Plan.
So while you have an annex or a section that talks about command and control in the emergency operations Center for the hospital, you still need to have those unit-specific policy and procedures, job action sheets & annexes.
You need appropriate unit-specific P and P, policy and procedure.

For example the emergency department, the dietary, housekeeping, infection department all have to have unit specific or unit-based emergency management plans that focus on what happens in that area.
Very important to understand.

It doesn't by wave of a wand take all that work away.
Sorry, everybody.
It's highly recommended that you have specific annexes for those emergency and disasters that are high prevalence or identified reflected highly in your area.
So for example you are know a tornado alley.
You might have a specific annex within your Emergency Management Plan that says, when there is a tornado, you might do these things first.
These are the positions you might want to have open first.
These are your impacted departments.
Things that help guide you.
So it's almost like emergencies for dummies that anybody could pick it up and say we're in a tornado, pull it out and follow the checklist.
Those are recommended things that are still needed.

Again, HEICS is not a replacement for training and exercises and so incorporated into the HEICS system is definitely some training and exercising materials to assist you.
Let's go back to the next slide or to the next slide, not back, I'm sorry, ICS staff positions and remember that basic incident command structure that I mentioned to you before with all those positions?
So keep that in your mind.
Let's talk for a moment about incident command.
Incident command is key.
An incident commander must have these skills.
Basically they have to have some pre-planning and training.
The initial response has to be orchestrated by an incident commander.
It doesn't mean your C.E.O. has to be on-site to be incident commander.
At 3:00 A.M. your nursing coordinator might be the incident commander.
That position is very important and it can be assumed by a number of people.
You want to make sure they understand some operations of the facility and when to open and de-escalate or stop activities or flex down as things happen.
And then, of course, when it should be terminated.

Those are some key things that an incident commander needs to be on top of.
We talked earlier about a span of control and what HEICS does is truly try to keep the span of control down to one to five.
So that they're overwhelming influx of data is not constant.
If you'll go to the next slide under ICS HEICS hierarchy, this is the literally the hierarchy of how the chart flows.
The first spot is incident commander followed by the section chief, the branch directors, the division group supervisors, unit leaders and the resource/officers.
One thing I want to quickly mention here that when we do the next iteration of HEICS the last box there, resource officer, that's a little confusing.
Under incident command we have officers.
We'll be clearing that up.
But for now let's call them resource people.

On the next slide when you see the full chart everybody don't faint.
This is the full HEICS chart and it incorporates 49 positions.
Now, if you're a major university medical center or a major medical center you may have even more positions for this.

More than this.
However, if you're a smaller hospital and you have 49 staff in your entire hospital, in just a moment I'm going to talk to you about how flexing up and flexing down to meet the needs of your event can help.
The next slide you'll see a chart and you'll see some boxes that are highlighted.
And what I would like to talk about it's now 3:00 a.m. and you're in your hospital and you happen to be the nursing supervisor and the ER calls and says we got an MCI and 30 people will be arriving at our doorstep pretty soon.
What I want to show you in this slide is the ability to flex up and meet the needs and yet not be overwhelmed.

One of the first positions that get activated would be the incident commander.
Other positions that would be important in this roster of people would be under the operations unit, which would be the treatment and triage unit because those people are going to be probably in the ER, correct?
So those would be very important people to have activated.
The other part that is going to be important to activate would be under the planning section under the labor pool.
Why is labor pool important?
Labor pool is important because the labor pool or the staffing secretary or the nursing supervisor may wear that hat also will know where there is staff within the facility that already exists that could be mobilized to the emergency department or area of the event and move them through the hospital to assist with that peak of patients that will be coming in.
So that is a very important position to have activated is that labor pool.
Other positions that surround it, say for example it's a train wreck and you're initially told you'll only get five victims so you're pretty geared up for those five victims.

However, if you then find that the victims, they found another car which they didn't think had people in it and now there is another ramp-up of people, then your chart and see at 3:00 a.m. knowing how many people are in the building, are there other people inside the building that might -- and inside the chart that might be really important to activate.
One of the persons that I can think of right off the bat would be somebody to look at the inpatient areas or the inpatient supervisor position even if you didn't activate all the unit leaders underneath there would be very important.
You would assume that some of these patients would need to be admitted.
So as the event unfolds and as more people arrive at the facility, that's a very important part of the plan, to flex up or flex out the number of positions that are needed according to the size of the event.
But at 3:00 a.m. when you have limited staff, those in lavender may be the only positions that you've activated.
On the next slide we have a storm alert.
And one of the things I'm going to so stress during this process of class with you today is that you can use HEICS not only for an event that just occurs, but also pre-planning for events that may occur.
And that's so important to understand.
For example, you're back east and the perfect storm is going to hit your shores.
So you know that in two to three days you may have this amazing event that you must accommodate.

Those areas that you see in lavender would be those positions that you would want to begin activating.
So, for example, the incident commander, of course, all those positions in lavender, the operations section.

But you don't have to go deep down into the chart yet.
That you would do only those things you needed for the event.
One thing I want to mention under logistics is that the damage assessment and control officer would be a great position under the facility unit leader to activate because that will be very important.
Again, this can be customized for your facility.
So if you don't feel that the labor pool unit leader is needed for pre-planning for a storm alert, that's okay.
What you do is assess those areas that need to be activated and activate those that are very important to activate.
I'm going to go over each of these positions in just a moment so if I'm jumping a little ahead please forgive me.
I hope that makes sense that you can use HEICS not only for actual events that occur, but also events that you know are going to occur or may occur and are going to really impact your facility.

I would like to give you one more example, kind of a fun example, of why -- how HEICS can be utilized.
The C.E.O. is retiring and you're giving him an incredible party to leave the premises with.
And you want to plan that party.
You can activate those sections in HEICS that make sense to you and have them be planning people for a party, a charity event, or a joint commission visit.
You could activate those special departments or special sections and have those positions be the command and control for planning for an event.
Again, the more you practice HEICS, the better you are.
So if you activate HEICS in small events or planned events or fun events, then when that big event comes, people understand how the system works.
So think of it as a tool like that.
I want to give you one more fun example of that.
Is an example of a wedding.
And everybody is going to be planning a wedding and who might you think is the incident commander?

Well, you would think the incident commander would be the bride.
Some people argue with me about the mother but I think the incident commander is the bride.
Logistics chief, who would that be?
That's sometimes the groom or maid of honor.
Making all the planning.
The planning chief is usually the mother or mother-in-law, right?
They're the ones seeing how everything is going and hopefully they're checking with the incident commander, the bride.
The operations chief is usually also the maid of honor, also the meeting planner, where they're actually going out and making sure that things are done and what is happening and things like that.
And poor dad is the finance chief who is going to be paying checks throughout this whole thing.

So if you relate that to something fun and relate it to something that is more common hopefully than emergencies you can see how the system really can be useful in planning, commanding, controlling and coordinating.
So that's the whole point of that story.
We'll go on to slide 47.
Again you'll see the entire HEICS chart.
And a couple of things I'm going to mention on the HEICS chart and then we'll underscore it a little bit later.

If any of you have been on the website and have downloaded the HEICS chart or have HEICS already in place in your facility you'll notice a big change here in this organizational chart and it's under command in the gray boxes, the medical staff officers.

In HEICS three we had the medical staff officer down in operations under the red part, under the operations chief, next door to the medical care director.
And there was a dotted line from the medical care director and the medical staff director up into command.
We understand and have heard loud and clear that with a hospitals especially there must be direct medical impact and input into the incident command structure to be effective.
Therefore, we have elevated or promoted the medical staff officer rather than being buried down in operations, we now have elevated them to incident command.
We feel that this is a very appropriate change and would like people to implement is right away even though the standard of HEICS is not integrated.
As I mentioned with the website change that will be reflected on the website in mid-September.
But medical staff officer is elevated.
We've also looked at the job description and changed the job action sheet.
So really incident command must have medical staff officer input.
That's a little side bar.

If we could go to the next slide and we talk about the ICS management practices.
I'm not going to read all those to you but if you think in your mind all of the things that you need to manage an event or an incident or a project you have, the planning, directing, organizing, etcetera, etcetera, is so very important.
Those are considered the management practices.
On the next slide if you look at again the ICS chart and you see the management structure of command.
And again, like I mentioned before, that medical officer is now front and center in the hierarchy.
And what I hope to do in the next few minutes is to go through with you each of these positions and give you an overview of all of these command positions.
The first position is the incident commander.
What is the mission of the commander?
To organize and direct and get information, make critical decisions, give direction for the overall hospital operations including authorizing evacuations if needed.

But also, the incident commander needs to have that global, global view.
If you think back in an emergency, think back to who was your best, best incident commander or leader of that emergency.
They didn't get into the minute details or into everyone's job.
They really stood back and made decisions from a higher level, a global level.
And so the incident commander is critical to really, really stand back.
I kind of joke with everyone when I give classes that the incident commander job is really the easiest job in the entire organizational chart because they literally get to sit there and wait until information and decision making needs are brought to them.
So they have to have that global vision.
When we move on to the safety and security officer, and what their mission is, their mission is basically make sure things are safe and secure, and make sure that the operations of the hospital remain secure, which include scene and facility security.
Traffic control, perhaps locking down your security.

Also that a security command post is essential and remember that when you're in the management structure and HEICS is activated and you're sitting in the emergency operations center, that safety and security officer is really garnering information from the troops.
This is not the person who is walking around with keys and gun in hand and walking the halls.
This is really a person who is garnering information, making final decisions on safety issues and really providing incident commander with information they need to make decisions.
So this is a person who really is a very, very important.
There have been many people in classes that feel that this role is too big and that there should be a safety officer and a security officer.
Because of the role.
My response to that is a couple of things.
Number one, remember the role of this person is not to be the doer but to be the overseer.

The second thing I say is, if you feel in your heart of hearts that safety and security should be two roles, please do that and break out those two roles.
You would have to make a decision, should safety and security officers, if there are two of them, both report to the IC or a sub hierarchy under that.
You want to watch that span of control from one to five.
Those are decisions that each facility can make and are valid.
One role I think is the most difficult in the hospital and in any emergency, actually, is the public information officer.
And boy, to have cameras stuck in your face and microphones stuck in your face and hopefully pray that you have the answers and are able to articulate those answers well so you're not in more hot water is very difficult.
But public information officer is an absolutely essential position in the hospital.
Why is that?

Mainly because that public information officer needs to truly collaborate with community PIO's who have consistent information and messages.
One of the things we have written in the PIO job description or job action sheet is that whenever they make a media message, the incident commander should have approval of all messages that go out.
We really like to stay with that.
That way consistency reigns.
That sometimes doesn't happen in larger incidences or larger facilities.
The public information officer position is very, very important.
This one needs to be pre-prepared and ready.
In addition to that having pre-prepared risk communication messages can be critical.
If your assessment shows you have a high number of tornadoes or flooding or evacuation for hurricanes or like California shaking it up with earthquakes, pre-scripted briefings and messages for the media is very important.
Other important role for the PIO is to have a pre-existing relationship with some of those media.

Because if that media know that you're going to give them information and that you're going to let them have access as appropriate, they're going to be much more nice to you and rather than fighting with you at all times.
They will interview that one doctor that went out for a smoke.
Important to control your media.
This is a really critical piece in the whole roster.
Another critical piece is the liaison officer.

And what is a liaison officer?
Basically it's the contact person for communication into and out of the hospital.
So, for example, this would be the person who is in touch with community responders, the emergency -- the community, county, borough or emergency operations center and other local officials outside of the facility not only to pull information into the facility about the status of what is happening out there in the world but also to provide information to those people for what is happening inside the facility, what your needs and critical issues are.
So this person is actually essential.
I always say this is one person as though it's only requiring one.
You might have support staff helping this liaison officer because I'm sure there will be lots of phone calls.

However, the role is very essential.
So remember to always have a liaison officer.
If possible even in smaller events.
It can really help.
In addition from the community standpoint, they can call and say I'd like to speak to your liaison officer and they can be pinpointed to a person to get information back and forth.
This will help you control the information that is going in and out of the facility and also know that the information coming into your facility is valid.
Liaison position is a really important position to underscore.
I've had lots of questions about it so I'm going over it very briefly here today.
If you have other questions about it do feel free to email me with your questions.
The next position that we mentioned here that just got a promotion is the medical officer.
And really, their job is to assign physicians, make sure that medical care is being delivered on a global basis in consultation with the medical staff officer that is in operations and in consultation with the labor pool people looking at the resources of doctors.
The most important part of the medical officer comes to advise the incident commander who may not have a medical background.
It might be the COO, the nursing supervisor or whoever is in that position at the time.
But really to advise the incident commander on issues related to the medical staff and the patients in the facility.

If you have to evacuate and the incident commander makes a decision to evacuate that ICU, that medical officer is really going to be the one to talk to the IC to tell them the risks and benefits and if that's a good medical decision.
They may have to take in other safety and security issues for that ICU that might take precedents but at least there is a medical voice stating the medical needs of the patients and the facility.
We feel it's important enough to kind of pop up to a higher position.
That kind of outlines the command staff or the administrative staff.
Some people are liking to call them the command structure, but the administrative portion of the command structure and command staff.
So that concludes that part.
We're going to go into the sections.
Each of the sections are very important.
Again, you flex up and down according to the need of the event, the size of the facility, and the size of the number of staff that you have to fill those positions.

The logistics section includes all those listed -- noted here and I'm not going to go into these in depth.
I'm just going to mention the sections in a more full class we go through each position outlining what they do.
Think of logistics chief as the radar O'Rielly of the mash unit.
The logistic chiefs get stuff, provides stuff and you can see under there all the kind of stuff that each of them provide.
So it's important that you think of them as the getters or the stuff that's needed to support the infrastructure of the facility and the operations of the facility.
On the next section is the planning section.
And on the planning section we have the chief and then all those divisions underneath this.
A couple of these sections are important for me to let you know about.
One of the sections is the situation status unit leader.
Like I mentioned in the full class we go more over this.

But the situation status unit leader is one of the most important position, if not the most important position of the planning section of the entire planning structure.
This is the unit that is going to make sure they have tracked all of the information and the situation not only within the facility, but from without the facility.
Outside the facility, excuse me.
So this is a huge position.
It is recommended clerical support be with this position because of all the data management.
However, this is a great major, major important position.
Another one I would like to mention is the labor pool unit leader and the medical staff unit leader.
Those are both labor pool type positions.
The nursing staff and the medical staff really being the medical provider of labor on the medical staff.

The next section is the finance section and as we talked about response and recovery are very, very important.
Finance chief, time leader, procurement claims and cost leader, all of these are important positions and while it doesn't seem like major positions while you're working through the incident, when we go over more in depth on each of those positions you'll see why each of those things are so important, as well as being able to track costs.
And if you can track your costs you have a possibility of recooping money for those activities and expenditures.
So this section is very, very important.
As you notice in the next slide under operations section.
The operations section is huge.
And this is where the work of the hospitals happen right here.
This is where care is delivered.
This is where activities of patient care and patient care activities happen.
So operations is very large.
So what I'm going to do is break it down just a little bit.

On the next slide you see the inpatient medical branch.
You notice I always leave the operation chief and the people immediately under that area and so you can kind of get an idea of the chart.

The inpatient area supervisor has all of these areas underneath them to supervise and to receive information from.
On the surgical services maternal, etcetera, etcetera.
Say your hospital doesn't have a maternal child leader, delete this from your chart.
On the other hand there are hospitals that have psych units, all kinds of different units that are not reflected here.
So one of the things your hospital would consider doing if you did or did not have those listed is to customize and expand as you felt was needed.
That's the inpatient area supervisor.

The next slide shows the treatment area supervisor which -- if it's an external event it's usually the emergency department that's on the hot seat but I want to really stress I think that for many years we've always focused our drills and focused on activities on patients coming through the ER.
I really think it's time for us to expand that.
What if our ER has exploded and we would definitely have another whole issue that we had to deal with.
So we have to remember in our Emergency Management Plan that not only is the ER impacted, but that every department should be impacted.
And that means also carrying that into all the drills so that not just the ER gets drilled but the entire hospital in some manner gets drilled.
Makes for a much larger exercise but can be very beneficial.
The treatment area supervisor.

They report to the medical care director and the ops chief.
And you see all those unit leaders underneath each of those.
I want to mention one thing about these -- two of the unit leaders.
The discharge unit leader, there is a great deal of discussion about that when I give classes.
Mainly the discussions reside around this unit and why it's needed.
In theory, the recommendation is that any patient no matter what division of the hospital they're in, that are discharged during an emergency, go through the discharge unit.
A couple of reasons for that.
Number one, you can literally track very succinctly each patient that goes out so you don't have a willy nily kind of discharge issue.
You can ensure patient safety of leaving the facility and make sure they have rides or get them taxis.

In the scurry of trying to get new patients in this really helps.
The other thing that this does is make sure that all of the discharge instructions, whether that be an ER discharge instruction, the patient understands because how many times in an emergency when you've got multiple criticals and you tell a minor treatment person just to read this and, you know, call if you have any questions to get them out and free the bed, the discharge area can really help lend some good things to that.
The morgue unit leader is under operations, under treatment area supervisor area and really there is great discussion sometimes about should the morgue unit leader be under here or logistics or where it should be.
We put it here because it is an operational area and it does receive input, unfortunately dead bodies, to the -- from the inpatient and treatment areas.
So that's why it resides here.
On the next slide you see two other sections.
And those sections are the ancillary services and Human Services.

I want to start with ancillary services quickly and start from there.

Ancillary services are very important services and those services must be supportive of the inpatient and out patient operations in order to be effective.
Again, if you don't have cardiopulmonary, you only have respiratory you can customize this to meet your needs.
If you have additional ancillary services that you can make use of and avail yourself of you can add those additional services here.
So again, customize as necessary.
I want to take just a moment again my soap box, sorry, folks, but Human Services director and how important this is.
One of the things we do very well is take care of our patients but sometimes we forget our staff need equal taking care of.
Three sections under the Human Services director are recommended.
That support which is everything from R & R during their shifts.
Bringing in food if needed for the staff.
Taking care of staff.
Providing a sleeping area if they have to stay over and can't leave the facility.
Basically anything that staff would need.
What does that include?

That may include psychological support and that is the next unit because we feel the two are really -- one is physical and one is psychological, I guess.
Psychological support would include everything from providing care or crisis counseling to any staff that would need it.
Also, it includes preparing messages and providing information to staff.
Because information is critical.
Putting a board in a common hallway where the cafeteria is of all the incidences that are happening.
All the newspaper articles, what is happening in the world while you're all dealing with it can provide psychological support to staff.
Dependent care is huge.
How many times have you heard when you've desperately needed staff, I could come in but I can't get a babysitter for my daughter or grandma or there are even people out there that need to be home with their pets and won't leave or come in because their pets are there and they need them there.
Dependent care can include pets, it can include any dependent care but you'll get a responsive staff if you can help provide them with some dependent care.

You may have lots more questions about these positions and if you read the HEICS manual it will give you some.
You're also very welcome to email me if you have questions and we'll take questions at the end of the sessions so that will leave you some time to do that.
One of the things I really want to talk about is the job action sheets.
These are provided in the HEICS manual and I'm going to kind of give you some of our wishes with HEICS.
But there is a job action sheet for each position on that HEICS chart.
The position, the job action sheet describes the mission and the function and a focused objective.
Then a prioritized activity list so you'll see immediate activities include boom, boom, boom, boom, boom and usually those are all -- they start with all the same ones.
For example, put on your vest and read your job action sheet completely.
Things like that.
But then it also gets down to immediate things that are important to pay attention to in the immediate, intermediate and long term.

That's the way the job action sheets are broken down.
Also, we really encourage those job action sheets to be customized to the organization.
Again, making sure that they look in the checklist form, that they are kind of like job action sheet for dummies where it's -- anyone could pick it up.
If I'm the dietary person and have to be liaison for the moment I can look at what my general role and scope is and make sure that I can follow that and I can check things off and say yep, did it, yep, did it.
Very important to help focus people on their roles.
Customization, one thing we do really encourage is that the job title and mission statement should not be altered.
Why do we say that?

One of the goals we have for HEICS is standardization across hospitals as well as across community responders.
For example, the community responder might want to talk to your operations chief or your liaison and if those titles get mixed and you don't use strict ICU titles the connection is lost and they get sent to 12 people until they can find the right person.
We really strongly encourage that you do not change the title but customization should be done in the activity lists and, of course, in the prioritization and making them fit to what your needs are.

It can even be customized to events.
For example, if a tornado, electricity might be high on the list, whereas in another event that might not be prioritized as a high activity event.
Consider those sorts of things.
The job action sheets really should be available immediately and one for each position.
I want to mention just a moment, I apologize for not doing it while the organization chart was up there, but one thing that is important to remember is that 49 positions in an org chart is a lot of people.
If you're a smaller facility or just the incident is not that large compression of positions can be done.
So, for example, if you can flip back to your org chart while you're sitting there if you have it printed.

For example, under the finance section it might be one or two people really doing all of those functions.
Or they could be split up and have just a few of those functions done.
So within those positions you can compress some that make logical sense.
And in a further HEICS class we talk about those crunching or consolidation of positions when we go more into depth on each of the positions.
Just keep that in mind.
Don't let the 49 positions scare you.
It really can be done manageably.
On the next slide we talk about the supporting forms that HEICS provides and while we don't claim that these forms are the be all, end all and that you should use them in order to use HEICS but you should definitely provide some form of those communication sheets forms when you plan your emergency operations center.

If you already have one you like or want to make one you like better that's wonderful.
Documentation is essential.
And any time you try to recoup costs or as we all have been told if it's not documented it's not done type of thing.

Documentation is imperative.
Any time that you can create a form that is driven on standardization and providing prompts for what information you need to capture the better it is.
Like I mentioned, fiscal recovery and liability protection comes with documentation and when all chaos is breaking loose in the middle of a disaster it's wonderful to go to page five and find what really happened.
And again scraps of paper, Post-It notes.
If your computer is like mine there is Post-It notes all around it, those fall down and get lost.
Forms that have people document on reliable consistent communication notes you're going to have better documentation in the long run.
That's highly recommended.

The next slide gives you a list of the supporting forms that HEICS provides but like I mentioned, these are -- there may be better forms than what we provide out there and we would be -- when we do the next iteration of HEICS we're hoping to get some forms that people are using.
But a couple of things I think is important to point out here.
Activity log.
Really important.
Simply because this is every single person in the position should have an activity log.
And an activity log documents basically.
I got a phone call from her, this is what I did, I responded in this way or I gave the message to so and so so you can go back and look.
Activity logs are absolutely great documentation tools in -- also because then if I just came on shift and I get a phone call, well I dealt with Jane in section such and such and she said this I can go back to Jane's log and I can find that.

So activity logs are hard because people are busy and don't think to write things down but if you can practice the activity logs they really are valuable.
The other thing I want to mention is the patient tracking form.
Because of time I won't go into great depth on the patient tracking form but there is a suggested system in HEICS about a pretty good patient tracking form that allows you to put patient information down but also keep track of where they are at the same time.
And so it's a really good form to look into.
The last thing I want to mention on the forms, two other things, one of the last things I want to mention on the forms is that message forms are imperative.
What's is message form?
I'm sitting at the planning desk and I get a call from a unit who got my number somehow somewhere and they want juice.
Well, the planning section doesn't provide juice to that unit but the logistic section does especially the nutritional supply person.
What I would do instead of transferring over to another person I'll take the information on the message form.

I'll write it all down and pass that form physically to my co-hort over in logistics and they can act upon it.
This is really important because in the chaos of an EOC it is important that things are written and people understand they need to follow up on them so it's much -- facilitates effectiveness with those message forms.
So I highly recommend them.
The other thing I want to mention about supporting forms is a lot of people ask can they be computerized?
Absolutely.

You do everything online.
Can you have a network set up in your EOC and share forms and share information that way?
Absolutely.
I think technology is finally catching up with the need people have for that information.
A couple of cautions and you all know these.
I know I'm preaching to the choir here today.
One of the things you always want to make sure is that you have redundant backup.

So if there -- a computer does go down or you lose electricity or whatever, that paper and pencil still be available so in your quest to electronic all your forms make sure you have a redundant system to back you up.
I would like to talk about administrative support of HEICS.
You always hear about the trickle down and up theory which is sometimes really good.
One of the things that HEICS absolutely requires is administrative support of the system.
Without it, you won't have success in your organization.
The gentleman pictured in this slide is a CEO and he was appointed CEO of a hospital in southern California and appointed as CEO in north ridge at a hospital in northridge, California.
He was appointed a year before a big earthquake and was a proponent of HEICS and implemented it over the next year when he was there.
And the earthquake happened.
If any of you have seen the pictures of northridge the facility pretty much collapsed.

Truly his leadership and his drive to gets HEICS as the management system is what helped that hospital survive.
And administer great care to their patients.
I can't underscore enough that administrative support is absolutely essential to achieving what you need to have.
Moving on to the next slide there are other job aids that are very important and not terribly expensive, which is the cool thing.
Some people have implemented HEICS for as many as $100.
Some people not including training, of course, the optional extras like when you buy a car.
But supplies, etcetera, really cannot be all that expensive which is really great.
One thing we recommend and I'm sure you've seen these is the position vests.
They're color coded to match the HEICS chart.
They need to have the position written on them not only in the back but on the front.
Please think of pockets.

I can't tell you how valuable pockets are.
The position vests are valuable because they immediately identify the section that the people are working in as well as if you're a big facility and you have people coming in that don't know one another by name, you can look at their vest and go oh, planning section leader, can I talk to you?
Or so and so, or they know what to look for and who to find and it does help a lot.
Quick start sheets are really -- pocket directory, pocket guides are those things we're all used to with different things.
We can pull them out, look them up quick.

Down and dirty cheat sheets and those are really valuable and we recommend those.

Clipboards are really important and you'll see the section listed on there and section bends are used to prepare your EOC.
If I were preparing an EOC with the sections I would buy yellow bins, blue bins, gray bins or at least label them in those colors with their section names on them and then everything that you need for that section to open up your EOC would go in that section bin.
If I were the planning section, and I knew that I had to activate my section I'm the planning chief, I'm going to go grab my blue bin, open it up and inside I should have job action sheets on the clipboards for each job action position.
I would have all the things that I need to fulfill my job, including forms, reference materials, things like that.
So the whole goal is to be able to pop a bin open, pull everything out and get started and not have to run araund to 86 sites to get the basics of what you need.

I mentioned office supplies a little, a bit.
I want to underscore office supplies and in the section bins are essential.
It's important to have pens and Post-It notes or message forms and I recommend those section bins.
They don't have to take a lot of room in a facility.
They can be in a closet where they can be easily accessed.
So consider those.
The other thing I highly recommend is status boards.
Status boards are used to be those great big white boards that are put up on walls so that the incident commander and other people can walk around and in a snapshot get a picture of what is happening in the facility.
It also allows operations to look over the planning unit and go oh, we have this happening.
We better get ready for casualties or for logistics to look over at operations and say my gosh there is an influx of another 50 patients with contamination needs.

We better look into decon equipment.
Status boards are a mechanism of communication.
Yes, they are another thing someone has to do.
So we have status board recorder positions built in to HEICS so that someone is assigned to maintain those status boards.
But they are valuable, valuable tools.
At this time I would like to open it up to questions.
I kind of went quickly because I thought we were going to be short of time but that leaves us a little time still.
But I would like to open it up to questions.

MODERATOR: Thank you, Cheryl for a great presentation.
We do have quite a few questions here.
First question is, does the liaison officer have to have a medical background in order to function in this role?

CHERYL STARLING: Great question.
And actually the liaison role does not have to be medically based.
They need to have a working knowledge, if you will, in order to ask some questions at times.
But in our experience, the liaison officer does not have to be medically trained.

Therefore, some of the things that we look at for liaison officer within the facility is you can use some of your department heads are good liaisons.
Sometimes your disaster coordinator, not your emergency department manager, so if you wear the same hat ladies and gentlemen, you can't do that.
But if you have a disaster coordinator that could fulfill that role who has the community links already, that's a great position to put there because they know the verbage.
They know the people perhaps.
But no, it does not need to be medically based.

MODERATOR: We have another question here.
It says, is the HEICS tool used or recommended by the CDC for disaster planning in the event of a biological disaster?

CHERYL STARLING: Great question also.
How do I answer that?
CDC very much recognizes HEICS.
Government agencies tend not to want to say a certain product.
But in CDC documents and if you look at the trend toward NIMS for all of the government -- federal government department it definitely talks about a unified command structure.
Does HEICS work for biological incidents?
Yes, it does.
However, we haven't made it user friendly, if you will, for biological incidents.
One of the things we hope to do soon is create HEICS version four which will incorporate all the CBRNE agents into the HEICS model.
So, for example, infection control would be a key player in a biological event.
Where would that infection control practitioner reside?
In operations in command, would the medical officer be and I.D. Doc.

There is a whole lot of questions we need to work out.
We have had inquiries and invitations from CDC to come down and present the HEICS model to them and they're very much in support of it.
Including FEMA.
FEMA actually has taken HEICS and created a model for FEMA-type responders that mimic -- that is the HEICS system but incorporated into FEMA education.
And so I think it's very much recognized out there as the model that is there because you can take it off the shelf, folks.
You don't have to invent it yourself.
So yes, they do recommend it.
It's hard for me to totally answer that question directly but it is being recommended and recognized by multiple federal agencies.
Including HRSA.

MODERATOR: We have another question.
It says, is there a separate plan for a lock-down of the facility?

CHERYL STARLING: That's a good question, too.
Remember as I mentioned, that HEICS does not replace policy and procedure for each unit.
So let me model you through it.
Say an event occurred that was sheltering in place issue and you were -- you had guidance that you needed to shelter in place that included a lock down of your facility.
That information would come immediately through the section chiefs into the incident command structure.

Commander, along with his administrative staff that would collaborate with them would immediately make the decision to do a lockdown.
The lockdown, the how-to lockdown is not in the HEICS tool so we don't tell you you do this and this and this you do that, all those sorts of things.
You would literally need a policy that would say how and what the facility would do to lock down.
Part of that policy and procedure, I would hope, would include the criteria or the reasons why a lockdown might occur which would assist the incident commander in making that decision in collaboration with his section chief and administrative staff.
HEICS doesn't have the policy and procedure but it has the mechanism for the decision making of the lockdown to occur.
Once that decision is made, the actions, the safety and security officer and the facility people would go into motion and conduct that decision.

MODERATOR: All right.
We have a question that asks, who should the IC commander be during normal work hours?
Should it be limited to the CEO or other administrators?

CHERYL STARLING: My recommendation that it not be the CEO.
Here is why I say that.
My recommendation is very highly it should be the COO or some other type person in the demarcation with normal working hours so I'll maintain and think those people are usually in the facility.
But the CEO is more valuable and can be utilized in other ways.
One thing I didn't mention to you in this section of the class is that the CEO also has a responsibility -- excuse me the incident commander has a responsibility also to conduct information up the hierarchy including to the board of directors if -- we recommend the CEO not be the incident commander but the policy or ultimate decision maker is as an asset to the incident commander and be the person that goes back and forth and interacts with the board of directors because that's what they do on a day-to-day basis.

There are some CEO's that make wonderful incidents commanders so I don't want you to rule them out.
You need to look at the need for your CEO to be tied up in that way because I didn't mention it in this section of the class but when you're in the EOC you stay there.
You're behind and super glued to the chairs from a certain level up.
And I'll tell you it's very hard for the CEO who may need to be out there doing press conferences.
Who may need to be out there talking with the board of directors or for moral support may walk around encouraging the troops and seeing what is happening.
The recommendation is the COO or someone that can get that global view of the facility is a better person usually to fulfill the IC role.

MODERATOR: Great.
We have a question here that asks, at our hospital, those that are involved in emergency planning are fairly new to the organization and have little experience in planning and development of an emergency plan.
Could you recommend any good training programs?

CHERYL STARLING: For emergency planning?

MODERATOR: Correct.

CHERYL STARLING: I'll tell you what, off the cuff, off the top of my head I want to look at my resource list.
So what I can do is, since these are the BHPP grantees I would be happy would work with Andrea.
I know Andrea and HRSA can come up with quite a few.
I'll work with them and put out a list on that on the list serve.
How is that for a non-answer?

MODERATOR: Sounds good.
We have a question here, where does the infection control professional fall within HEICS?

CHERYL STARLING: That's a great question.
As I mentioned before, that's a great debate even among all our HEICS users.
Depends on the event.
In a bio event infection control, your infectious disease physicians and staff are front and center in the incident.
As I mentioned before, we've had discussions that in a bio incident the chief of infectious disease is usually going to be asked to be the medical staff officer because they have that background versus if it were a traumatic event you would put a -- possibly the trauma head as Chief of Staff or something like that in there.

So the infection control practitioner really is an area that we have great debate about so I hate to -- until we get HEICS for and address it standardized I hate to make a recommendation.
People talk about it in various ways.
So -- but I want to stress that if you have an event and you need your infection control people, plug them into where you feel is most appropriate.
My first hit, this is Cheryl Starling's opinion not standardized through the HEICS manual is I would put them under operations to give you a ballpark until its finalized reporting directly to the medical care officer.
They can be global and advise through all the patient care areas and still fit within a structure and a reporting hierarchy.
So if I had to tell you right today what I would do that's what I would do.
I do want to tell you that's something we'll be working on an make a standardized recommendation for everyone.

MODERATOR: Great.
We have a question.
Do you have a form to track not only patients but volunteers and staff if they're involved or exposed to some type of contamination where you could track these people to make sure they get proper treatment?

CHERYL STARLING: Yes, that would come under a couple of places in the HEICS chart.
Number one if you knew they were exposed you would immediately send them to your emergency department or some kind of employee health or something for initial treatment.
There is a couple of things that you would integrate into that.
Number one, you would definitely, your finance unit would definitely be activated and would -- you have a claims unit under there.

You would immediately do all the paperwork and follow-up that is necessary for that claim because you need to protect your employees and take care of them first and foremost to have a healthy workforce.

The other thing that would happen you might need some psych support so the human resource aspect would be there.
The follow-up treatment would really be under your employee health if you have that or some kind of arm and that is not reflected immediately on the HEICS chart but we would put that through the claims unit process and making sure that the paperwork was done.
When the crisis was done appropriate follow up would be insured.

MODERATOR: We have another role question.
Where would a Hazmat decon team fit?

CHERYL STARLING: Great question again.
Once again, we have great debate so I'm going to give you some of the points of debate.
As I mentioned when we do HEICS for which we'll address all those CBNRE issues.
Those will be definitely addressed.
There are two thoughts.
The first thought is that the Hazmat team, if they're the actual deconers, the once actually mobilized to the scene to do decontamination in your facilities, those would be listed under operations.
Our suggestion would be.
This isn't standardized, everybody.
I'm telling you what we're thinking.
Our suggestion would be that they become a separate unit off of operations so you would have inpatient, outpatient, ancillary, human resources and Hazmat or decon or whatever that might be.

That it would become an arm off of operations.
If you're looking at the decon team or the Hazmat team that only is going to supply you things.
So for example they'll be the team to pop up the tent, turn on the water but not provide physical decon or at least directional decon that would be under logistics.
One of the things we've been grappling with is how to define it and where best to fit it in the chart?
I sound like a broken record.
In our next iteration of HEICS we hope to have that standardized and defined and get all your input while we're doing that process so we don't do it in isolation.
So look forward to the next iteration in order to get a firm answer but that's my kind of off the top of my head answer.

MODERATOR: What would you say in a large organization, where would you have the EOC, the officers and the chiefs?
Would there be one or a separate command rooms or areas for them?

CHERYL STARLING: That is a great question and things people grapple with all the time.
A couple of considerations for your EOC.
I'll start with personnel as that was one of the questions.
There is great value in everyone in the structure, the HEICS organizational structure being in one room.
They need to walk across the way or wave to so and so.
Communication needs to occur not only up the chain but across the chain.
So if the ICU unit leader needs some juice for her ICU patient she can walk over to the nutritional supply person and do what she needs to get that affected.
I know it's a simple example.

The cross communication as well as upward, hor zontal communication has to be there.
So we highly recommend they be in one room.

We also recommend that you have ancillary off-site rooms that you can go into if you need a little quieter environment.
For example, the incident command and administrative team might need a separate room to have an IC briefing or out of the way decision making time.
Having a place close to the EOC that they can go to is imperative.
Also when we talked about the status board, one of the value of the status board is me in operations to be able to look up and say they'll get me decon equipment.
I don't have to make other calls.
You lose the cross communication if you're in separate areas of the hospital or separate rooms.
So we do recommend one room.
How to pick the room.

It has to be big enough to accommodate the number of people that you may need.
It also has to be plumbed or pre-plumbed, if you will, with phone lines and with potentially computer terminals or with fax machines.
So some thought needs to really go into how to set up and manage your EOC within your facility.
Because you want to make sure that when you get in there you aren't all trying to use one phone line.
Majorly bad.
Also the other thing is if you're trying to all use one or two phone lines and you go no problem I'll go back to my office and use my phone line there boom you've just lost your collaboration and your command structure.
So I think it's really important to be in one room but the room has to be pre-ready for that room.
In addition, you also want to remember that that room might not be useable for whatever reason and to have another site identified in your hospital for that purpose is really important.

MODERATOR: We have a question, we have started testing our call tree on a regular basis separate from our testing plan and we're finding out that initially we're only contacting a small percent of our employees.
Is that to be expected?

CHERYL STARLING: I hope I'm answering the question correctly.
If not please call it in again.
But yeah.
I think that's absolutely to be expected.
Depends on the time of day that you're calling people.
Depends on the day of the week you're calling people.
People tend to be mobile and not so much home bodies anymore.
One of the things we've suggested to people is that a lot of people have cell phones and beepers now.
And typically on call sheets what people do is just put home phone numbers.
So some people have recommended asking staff if they'd be willing to give their pager number or their cell phone number for disaster purposes.

Now they may not want to be giving you those numbers if you're going to call them every time there is a shift that's vacant.
You could say on our disaster list if we had to get ahold of you, could we.
In my experience and many of you out there probably had a similar experience.

Sometimes you'll go through the call tree and not get a single person.
It's why looking at alternate ways of getting ahold of people is important.
In my experience as an emergency department director we also had a contract with the local radio station that if we needed to, and everybody tuned in to that radio station during a disaster, the local news station, we had a contract with them that if we needed to, we could announce all staff or all nursing staff or of XYZ hospital please contact the hospital or please come to the hospital or, you know, whatever the scenario may be.
Really look at your call list as only a starting place and look at those other ways people can be contacted and notified if needed.
So let your imagination go wild.
I don't know if anybody else has had a similar experience but call sheets are limited by the person sitting on the phone at the time you're calling them.
Any other questions?

MODERATOR: We have another question.
It says, how will the federal decision to adopt a new national ICS change how hospitals use HEICS?

CHERYL STARLING: That's a really great question.
I think the proof is in the pudding down the line.
But in my initial read of that as well as my sense of what they want to do with it and also I don't know if many of you are familiar with a product called mayhem, which is also gaining some momentum out there that fits in with NIMHs they orchestrate well with HEICS.
We've had meetings with -- we've had discussions about NIMHs and meetings with the mayhem people and other people out there with the ICS-type systems.
We believe that those systems are very much well going to merge because they are based on ICS and unified command principles and the communication down the chain, if you will, is very important.
So in my own personal belief I feel that it will be only an enhanced communication methodology because they're all going to fit really well together.

MODERATOR: We have another question.
It's, is there a website where you can download the HEICS version three 1998 manual?
And if so, is there also a place that lists like the recent changes to the HEICS system?

CHERYL STARLING: Great question.
In the presentation I don't know if you have all downloaded the presentation, but in the presentation it does cite the website.
I'll speak it slowly right now.
But also at the end of the presentation it's my contact information and I can email me and I can send you the website.
Please don't email all 140 you on the same day because I'll probably go crazy but please, I am here for liaison and questions and I'd be happy to help.
The website to go right to the HEICS
-- that's where you can going to right directly to the HEICS website.
You can download entire version three.
I want to warn you it's 200 pages long.

If you really don't want to download 200 pages at a time, do volume one.
It's really the meat and potatoes of the system.
Two has training and other information such as that.
If you're interested in only the first part do volume one of the version three and then you won't have such a large download.

That's only about 90 pages.
I'm sorry to say we don't mail out the HEICS manual.
I get lots of requests can you mail it to me.
Do to costs, etcetera we don't mail it out but I can refer you to the website and email it to you if you need me to.
The second part of the question, Don, I'm sorry, I'm blanking on.

MODERATOR: The second part of the question was, any recent changes to the HEICS system, is there a website for that?

CHERYL STARLING: Thank you.
That will be on the same website everyone but it's not constructed yet.
So as I mentioned before, mid-September please revisit the website.
Mid to end of September revisit the website and we hope to have it reconstructed and all the new information I mentioned today will be on it.

MODERATOR: Can you please list the email for where people can request a video again?

CHERYL STARLING: My email that's listed at the end of the presentation.
Or you can do HEICS @ EMSA.CA.gov.
Both of those will get to me and I can send out the video.

MODERATOR: Great.
We do have another question here that just came in.
It says we are a small facility in a state that is not very populated.
Should we try to set up a decontamination site or should we try to involve the national guard or a larger hospital?

CHERYL STARLING: Now we're out of the realm of HEICS and I'll give you my opinion, everybody.
But we're really outside of the realm of HEICS.
But in working with the California hospital bioterrorism program we have rural hospitals with lower populations also.
The issue of decontamination comes up in my mind of how mapped should we get.
Should we have six reportable facilities?
What is the level of decon?
I would just pose two questions to you.
Number one, I think that having resources to call upon, whether that be your local Hazmat team, your local guard unit, your local military base, your local 911 provider to call on is in my mind should be considered not a primary resource but a secondary resource.
And that at some level, at some way hospitals need to have the capacity to do some sort of decon even if it's more of a garden hose being sprayed across the parking lot.
Whatever needs to happen.

Only because in a true large incident or any type of incident, field responders and potentially military may be unavailable to you.
So I think some plan needs to happen at every hospital level no matter how big and small.
I worked in hospitals that had the two kiddie pools and the sump pump so I know what you're faced with and the resources financially are not high for any hospital, even large hospitals.
So really try to look at your hazard in my opinion, look at your hazard vulnerability assessment.

Look at the scope and the type of decon you might be faced with and then plan appropriately, not only financially, but asset wise.
What is appropriate for your area.
I hope I answered that question well enough.
Really this is sort of off the HEICS and I don't claim to be the expert on this at all.
I hope that kind of answered your question.

MODERATOR: There is a question about training members of your branch.
Which would be better, to train them together or to train them independently?

CHERYL STARLING: Great question.
My personal opinion I think training is good no matter what happens.
A lot of hospitals will train branch by branch, which is very fun.
So one -- maybe one month you do the planning branch and the next month you train the ops branch and the next month you train this branch and that branch and at the end of the year you plan all the branches to interact together.
There is value in training, absolutely.
And the great thing about HEICS that provides you with those job action sheets so even if you've trained all this staff and every one of them are in Bermuda during the big one you can still have people that can function.
So yes, training and exercises is important and people do break it down by branch and it kind of makes it a nice bite-size piece.
Position by position I don't in my personal experience, I think has some value if you're just explaining the position but the real training comes from the interaction and the chain of command and performing those job action duties.
I would recommend branch by branch versus position by position.

MODERATOR: Great.
We have a question here.
How does the level of command shift when outside authorities take control such as fire departments or state health departments?
They're using the example of if it was like a smallpox outbreak.
How does that level of command shift?

CHERYL STARLING: Excellent question and I think hospitals -- I have no easy answer.
And I think that this comes back to the basics of pre-planning in the area with community leaders.
There are some states that I've taught in where literally fire comes into the facility and takes over emergency response and emergency planning.
If that's the way your system is, then you have to adapt to that.
You have to discuss that with people.
You have to have pre-planning of what the hospital needs to happen when that happens.
And so I don't have an easy answer for that.
What I have to refer you back is to that important pre-planning that must occur before an incident occurs of how the community works together and how you as a hospital integrate into that.

In my personal opinion and experience, I think it is counter productive for an outside agency that does not necessarily understand the interworkings off a hospital to take command of the hospital because of the intricacies of patient care and other functions that occur in the hospital.
It is is better that that liaison, PO and incident commander all come together so that emergency management community operating outside of your facility understands that you are part of their response and that you are integrated into

their response and that you are there for them and they are there for you, but command and control doesn't have to be orchestrated by an outside agency.
I think hospitals know how to run hospitals so in my personal opinion I would like to see the hospital run and integrate well into that community response.

MODERATOR: Great answer.
We have another question.
It says, who is the recommended person within the hospital to head up an emergency planning?

CHERYL STARLING: Oh, hard question.
Let me put it this way.
Anybody with great interest and motivation.
That could be the janitor for all I care.
It takes a passion.
In my experience if you don't care, your Emergency Management Plan will reflect that non-caring.
I can speak to experience.
It has been all over the boards.
Most of the time in smaller hospitals and in -- where funding is an issue the emergency manager plays that hat and has disaster preparedness.

In those fortunate hospitals that have a dedicated disaster planner they have models that I've seen that work very well.
Some bring EMTs or emergency planners from the outside into that position, that dedicated position.
Some have internal people who have that passion.
So the most -- biggest guide I would have and in my experience is if you have somebody that is passionate about it or understands the necessity of it, and is willing to bloody their head day after day hitting their head against cement getting people in the facility to understand how important it is that's your person despite credentials.

MODERATOR: All right.
We have a comment from Ed in Oklahoma.

CHERYL STARLING: Okay, Ed.

MODERATOR: Please make sure the fourth section, the ops, the log, the plan, the administration stay at the ICP and not roaming the situation.
Let your staff advise the section head on what is happening.

CHERYL STARLING: Ed, thank you for making that comment because as I mentioned, in the next level of the class we go more into that.
But if you could look quickly everybody at your organizational chart you'll notice in the org chart that as Ed said very well, there is several positions below the section chief and those positions really are the ones -- I'm looking for my org chart, sorry, guys, those positions are really the ones that never leave the EOC.
And basically it's anybody that is named a unit leader are the ones that pretty much stay -- anybody that is a unit leader are the ones that semi get to roam around.
But when you look at the section chief and you look at different higher level people, those people always stay in your EOC.
So you would never let them go out of the EOC, in theory.
Ed, you're right.

They're pretty much super glued to their chairs and need to stay there for what is needed for the department.

MODERATOR: Well, we would just like to thank you, Cheryl, again for a great presentation.
I just wanted to remind our viewers that an archived version of the webcast will be available for your viewing pleasure at MCH com.com And just like to thank everybody for joining.
Thanks so much.

CHERYL STARLING: Thank you, everyone.